



SUMMARY REPORT

ICD-9-CM COORDINATION AND MAINTENANCE COMMITTEE

September 16-17, 2009

PROCEDURE DISCUSSIONS

Introductions and Overview

Pat Brooks welcomed the participants to the ICD-9-CM Coordination and Maintenance (C&M) Committee meeting. Approximately 325 participants registered to attend the meeting. For the first time, the Centers for Medicare and Medicaid Services (CMS) was able to provide phone lines for additional participants to listen to the discussions. A total of 225 phone lines were provided on a first come, first serve basis for callers to listen to the presentations. The agenda and handouts were posted on CMS' and CDC's websites in advance of the meeting to allow listeners to follow the discussions. The PowerPoint slides used by the clinical presenters could not be posted on the website since they did not meet posting restrictions. Callers were not able to make comments or ask questions during the meeting since they participated in listen - only mode. Callers were encouraged to send their written comments after the meeting.

The procedure portion of the meeting was held on September 16, 2009 and was conducted by staff from the Centers for Medicare & Medicaid Services. The diagnosis portion of the meeting was held on September 17, 2009 and was conducted by staff from the Centers for Disease Control and Prevention (CDC). Discussion of ICD-10 topics was scheduled for the morning of September 16 and was jointly led by CMS and CDC.

An overview of the C&M Committee was provided. Procedure code issues discussed at the September 16, 2009 meeting are being considered for implementation on October 1, 2010, unless there is a request for an April 1, 2010 implementation to capture new technology. Pat Brooks reviewed important dates within the timeline with the meeting participants. The participants were encouraged to refer to the timeline for future meeting information and the deadline for receipt of public comments. Important dates include the following:

October 9, 2009

Deadline for receipt of public comments on proposed code revisions discussed at the September 16-17, 2009 ICD-9-CM Coordination and Maintenance Committee meetings for implementation on April 1, 2010.

November 20, 2009	Deadline for receipt of public comments on proposed code revisions discussed at the September 16-17, 2009 ICD-9-CM Coordination and Maintenance Committee meetings for <u>implementation on October 1, 2010</u> .
January 8, 2010	Deadline for requestors: Those members of the public requesting that topics be discussed at the March 9 – March 10, 2010 ICD-9-CM Coordination and Maintenance Committee meeting must have their requests to CMS for procedures and CDC for diagnoses by this date.
February 12, 2010	On-line registration opens for the March 9 – 10, 2010 ICD-9-CM Coordination and Maintenance Committee meeting at: http://www.cms.hhs.gov/events
March 9 – 10, 2010	ICD-9-CM Coordination and Maintenance Committee meeting.
September 15 – 16, 2010	ICD-9-CM Coordination and Maintenance Committee meeting.

It was explained that the Committee meetings serve as a public forum to discuss proposed revisions to the ICD-9-CM. The public is given a chance to offer comments and ask questions about the proposed revisions. **No final decisions on code revisions take place at the meeting.**

A summary report of the procedure part of the meeting will be posted on CMS' website at: www.cms.hhs.gov/ICD9ProviderDiagnosticCodes

A summary report of the diagnosis part of the meeting will be placed on NCHS' web site at www.cdc.gov/nchs/icd9.htm

The public is offered an opportunity to submit additional written comments by mail or e-mail until November 20, 2009. E-mail comments are preferred since this avoids delays in mailroom screenings and deliveries.

Comments on the **procedure** part of the meeting should be sent to:

Pat Brooks
Centers for Medicare & Medicaid Services (CMS)
CMM, HAPG, Division of Acute Care
Mail Stop C4-08-06
7500 Security Blvd.
Baltimore, MD 21244-1850
Patricia.brooks2@cms.hhs.gov

Comments on the **diagnosis** part of the meeting should be sent to:

Donna Pickett

CDC/NCHS

3311 Toledo Road

Room 2402

Hyattsville, MD 20782

Dfp4@cdc.gov

CMS ICD-9-CM homepage

CMS has information on ICD-9-CM on the following web address:

<http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes> . Detailed information is provided on the homepage on the process of requesting a new or revised code. CMS implemented an online registration for the ICD-9-CM Coordination and Maintenance Committee Meetings which will be opened approximately one month prior to the meeting. A link to the registration site is provided above as well as on the ICD-9-CM homepage.

Process for requesting code revisions

The process for requesting a coding change was explained to the audience, and is also explained on the ICD-9-CM CMS website. The request for a procedure code change should be sent to Pat Brooks at least two months prior to the C&M meeting. The request should include detailed background information describing the procedure, patients on whom the procedure is performed, any complications, and other relevant information. If this procedure is a significantly different means of performing a procedure than is already described in ICD-9-CM, this difference should be clearly described. The manner in which the procedure is currently coded should be described along with information from the requestor on why they believe the current code is not appropriate. Possible new or revised code titles should then be recommended.

CMS staff will use this information in preparing a background paper to be presented at the C&M meeting. The CMS background paper includes a CMS recommendation on any proposed coding revisions. The background paper is distributed for discussion at the C&M meeting and posted on the website for viewing after the meeting.

A presentation is made at the C&M meeting, which describes the clinical issues and the procedure. CMS staff will coordinate a discussion of possible code revisions. The participants at the meeting are encouraged to ask questions concerning the clinical and coding issues at the meeting as well as in writing after the meeting. Comments concerning proposed code revisions are taken for consideration. Final decisions on code revisions are made through a clearance process within the Department of Health and Human Services. No final decisions are made at the meeting.

April 1 code updates

The participants were informed that CMS did not receive any requests for an implementation date of April 1, 2010 for the procedure code topics being discussed this day. If such a request

were raised at the meeting, participants would be asked to provide comments on whether a code should be created and if the code should be implemented on April 1, 2010. Comments on an April 1, 2010 implementation would be due by October 9, 2009.

Information on any new codes that would be implemented on April 1 of any year will be posted on the CMS ICD-9-CM website by early November of the preceding year. Detailed information on this issue is provided in the ICD-9-CM timeline which is included along with the agenda for the meeting.

There were no requests made at the meeting for an April 1, 2010 procedure code implementation. Therefore, there will be no new procedure codes implemented on April 1, 2010.

Final decisions on new ICD-9-CM codes

As indicated in the timeline, the public is informed of approved ICD-9-CM code title updates through the inpatient prospective payment system (IPPS) proposed rule. This proposed rule is anticipated to be published in April 2010. Any codes approved after the March 9-10, 2010 ICD-9-CM Coordination and Maintenance Committee meeting will be included in the IPPS final rule published by August 1, 2010. A complete copy of the addendum will be published on CMS and CDC's websites by early June 2010.

ICD-10 MS-DRG Conversion Project

Pat Brooks provided an overview of the ICD-10 Final Rule (74 FR 3328) published on January 16, 2009. Information on ICD-10 along with the final rule can be found on CMS' website at <http://www.cms.hhs.gov/ICD10>. ICD-10-CM and ICD-10-PCS will be implemented on October 1, 2013. ICD-10-CM/PCS will replace ICD-9-CM diagnoses and procedures. ICD-10 Fact sheets and bookmarks were also provided to the audience. Electronic copies of these fact sheets can be obtained on the ICD-10 website.

There will be a single implementation date of October 1, 2013. This will include those ambulatory and physician services that occur on or after October 1, 2013 and those inpatient hospital discharges that occur on or after October 1, 2013. ICD-9-CM codes will not be accepted for Medicare services provided on or after October 1, 2013.

CMS has worked collaboratively with the American Hospital Association (AHA), the American Health Information Association (AHIMA), and CDC to develop a series of Outreach calls on ICD-10. There will be additional educational efforts such as this in the future. Information on educational resources can be found at: http://www.cms.hhs.gov/ICD10/05_Educational_Resources.asp#TopOfPage Those not attending the meeting can order the fact sheets; information for ordering bulk copies is available on the Educational Resource website under "Related Links Inside CMS".

Information on the outreach calls, including slides discussed during the calls as well as a copy of the transcript for the calls can be found at: http://www.cms.hhs.gov/ICD10/07_Sponsored_Calls.asp#TopOfPage

Information on future calls will be posted on this website.

Pat Brooks, CMS and Rhonda Butler, 3M discussed the ICD-10 MS-DRG conversion project. The slides present details of this presentation.

Freezing of Codes Prior to Implementation of ICD-10

At the March 11-12, 2009 meeting it was announced that there would be a discussion on whether there was a need to freeze updates to ICD-9-CM and/or ICD-10 prior to the implementation of ICD-10. The audience was asked to consider this issue and be prepared to discuss the topic at the September 16-17, 2009 ICD-9-CM Coordination and Maintenance Committee meeting. The first part of the meeting was devoted to this topic.

A list of questions regarding whether there should be a freeze was posted prior to the meeting on CMS' website and distributed at the meeting. CMS received some comments in advance of the meeting. Pat Brooks summarize these comments as follows:

No ICD-9-CM or ICD-10-CM/PCS updates beginning October 1, 2010 (36 months for implementation activities without annual code updates)

This approach involves updating ICD-9-CM and ICD-10 codes on October 1, 2010 and not updating again until after ICD-10 implementation on October 1, 2013. The commenter mentioned the extensive work needed to prepare for the transition to ICD-10 which will affect vendors, payers, providers, trainers, clearinghouses, and all claims handling organizations. The commenter stated that the 36 months between the last ICD-9-CM and ICD-10 updates on October 1, 2010 and the implementation of ICD-10 on October 1, 2013 were necessary to prepare and train for the transition.

No ICD-9-CM or ICD-10-CM/PCS updates beginning October 1, 2011 (24 months for implementation activities without annual code updates)

This approach involves updating ICD-9-CM and ICD-10 codes on October 1, 2011 and not updating again until after ICD-10 implementation on October 1, 2013. The commenters raised similar concerns to those mentioned above. The commenters stated that if codes continue to change it will make it difficult for vendors, payers, and providers to be ready and for coder training to be successful. One commenter suggested that a provision be developed to perform emergency updates to capture new technologies or new diagnoses.

Alternative to the comment above:

No ICD-10-CM/PCS updates beginning October 1, 2012 but continue annual updates to ICD-9-CM

This commenter supported annual updates to ICD-9-CM to capture advances in medical science. However, the commenter supported a freeze of ICD-10 beginning October 1, 2012 to give the industry time to update systems and prepare for ICD-10.

No ICD-10 updates on October 1, 2012, but update ICD-9-CM without interruption. (No period for implementation activities without annual code updates)

The commenter recommended no ICD-10 updates on October 1, 2012, but then updating ICD-10 again on October 1, 2013. The commenter recommended updating ICD-9-CM continuously through a final update on October 1, 2012. The commenter stated that having a two or three year

gap between updating the code books would lead to a loss of data. The commenter stated that there is a need to retain the ability to update the code books to capture conditions such as Swine flu.

Update both ICD-9-CM and ICD-10-CM/PCS annually through October 1, 2013 (no period for implementation activities without annual code updates)

The commenter stated that codes should not be frozen prior to the implementation of ICD-10. The commenter stated that freezing the updates would inhibit the recognition of new technologies.

Many of the commenters suggested a resumption of updates to ICD-10-CM/PCS beginning on October 1, 2014. However, one commenter suggested annual updates of ICD-10-CM/PCS without interruptions including on October 1, 2013.

Participants were reminded that final decisions regarding the freezing of ICD-9-CM and/or ICD-10-CM/PCS will be subject to the rulemaking process.

The topic was then opened for public discussion.

CMS had a variety of comments from the participants that mirrored the advance written comments. These comments ranged from those supporting a complete freeze for both systems to those who recommended that both coding systems continue to be updated annually prior to ICD-10 implementation. There were also comments which supported a more limited update process beginning on October 1, 2011 or October 1, 2012 which would allow only a small number of new codes to capture new technologies or new diseases. A number of commenters pointed out that Section 503(a) of Public Law 108-173 included a requirement for updating ICD-9-CM codes twice a year to capture new technologies. The commenters stated that CMS must make a provision to capture new technologies despite any requests to freeze code updates.

Commenters voiced concerns about the impact on vendors creating new ICD-10 products when both ICD-9-CM and ICD-10-CM/PCS codes were being updated annually. Some commenters stated that vendors and educators were reluctant to begin ICD-10 products and training materials until there was a period of stability without annual updates. Others stated that it was important to update codes annually so that information on new diseases and technologies can be captured. These commenters stated that vendors, providers, system maintainers, and coders were used to annual code updates, and that they should continue.

One commenter requested that ICD-10-CM codes be frozen on October 1, 2011 so that these codes could be coordinated with the Diagnostic and Statistical Manual of Mental Disorders (DSM), fifth edition. The American Psychiatric Association plans to publish the fifth edition in 2012. Updates to ICD-10-CM on or after October 1, 2011 would disrupt those plans.

One commenter suggested an approach that would greatly reduce the number of updates and provide more stability in the coding systems during the implementation period. This commenter suggested that the large, regular code updates on ICD-9-CM be discontinued beginning on October 1, 2011 or October 1, 2012. The commenter suggested that CMS and CDC raise the bar

for new code requests at that time and only consider requests for new codes that clearly describe a new technology or a new disease. The commenter stated that this may lead to the creation of some new procedure codes which do not ultimately receive FDA approval, as is the case now. For this reason, it was recommended that a new series of procedure codes be established during the implementation period. This new series would be set aside for new technologies. These codes would be assigned in sequential order in the newly established series and not inserted into the appropriate body system part of the ICD-9-CM codes. A minimum number of index and tabular entries would be created.

Analysis subsequent to the meeting

A new series of unassigned codes could be created within the chapter Operations on the Ear (18-20). There are currently three complete categories available (18.8, 19.7, and 19.8) which would allow for the creation of 30 new technology codes. There are also a number of three digit codes within this chapter which could be expanded to four digits and used specifically to capture new technologies (e.g., 18.4, 18.5, 18.6, 18.9, 19.0, 19.3, 19.4, 19.6, 19.9, 20.1 and 20.8). The existing codes could either be assigned a new four digit code with the new category (e.g. code 18.4 would become 18.40), and the remaining 9 unassigned codes, 18.41 – 18.49, could be used to capture new technologies. Expanding these three digit categories to four digits could create 99 new codes to capture new technologies. Combined, these two approaches would allow for 129 new technology codes. **CMS would be interested in receiving additional comments on the recommendation to create a new series of codes specifically devoted to capturing new technologies during the ICD-10 implementation period.** CMS is also interested in receiving additional comments on the issue of whether or not regular code updates should continue.

Request for additional written comments

CMS and CDC are interested in receiving additional written comments on whether or not updates should be restricted prior to October 1, 2013. These written comments should be sent to Pat Brooks, CMS (patricia.brooks2@cms.hhs.gov) and Donna Pickett, CDC (Dfp4@cdc.gov) by December 31, 2009. This information will be used in preparing a proposal concerning ICD-9-CM and ICD-10-CM/PCS updates that will be included in the inpatient prospective payment system proposed rule to be published in the spring of 2010. Decisions concerning any modification to code updates will be subject to formal rulemaking.

Expansion of Abbreviated Code Title Field

Commenters were requested to provide input on the issue of expanding the field length of the abbreviated code titles. Currently, ICD-9-CM codes are abbreviated to 24 characters. Two vendors in the audience stated that they have each established 48 character fields for their ICD-10 products. Any additional written comments on this issue are welcome.

ICD-10 Vendor Products

At the March C&M meeting there was concern expressed about the lack of ICD-10 vendor products. CMS announced that it would provide an opportunity for vendors to briefly share information about any ICD-10 products that they have developed such as code books or software. The floor was opened for comments on this issue. Two vendors stated they were developing both code books and software products. One of the vendors indicated they would be

publishing books next year while another vendor stated they currently have both an ICD-10-CM and ICD-10-PCS code book available for purchase now.

Topics:

1. Insertion of Drug-eluting Stent into Superficial Femoral Artery

James Gardner, MD, conducted a clinical presentation on the Zilver® PTX™, a self-expanding nitinol stent with Paclitaxel coating, and its effectiveness on peripheral arterial disease when inserted into the superficial femoral artery (SFA). Ann Fagan led the coding proposal discussion. Ms. Fagan reviewed the current codes that exist to describe the insertion of a drug-eluting stent in a peripheral vessel, 39.50, Angioplasty or atherectomy of other non-coronary vessel(s) and code 00.55, Insertion of drug-eluting peripheral vessel stent(s). One commenter asked Dr. Gardner if he could elaborate on the prevalence of peripheral arterial disease (PAD) in other areas and if he knew of other areas that would be viable for stenting in the future. Dr. Gardner responded that he could not give exact numbers; however, it is known that PAD exists in the carotid and coronary arteries and he is aware of manufacturers currently developing new products to treat PAD. One commenter questioned how often this procedure is being performed. In response, another commenter stated it is commonly performed as she codes cases describing the use of stents in the SFA very frequently. One commenter asked if there is a reason why no one had ever applied for a new code prior to now if this procedure is commonly done. Dr. Gardner replied that the technology appears to be effective although he has not seen the pivotal study data yet. He also noted that the manufacturer may apply for a New Technology Add-on Payment in the near future. Dr. Gardner stated he is not sure if there was a compelling reason to request a unique code for this technology prior to now. Another commenter recommended taking ICD-10-CM/PCS into consideration and possibly adding more specificity to ICD-10 after learning earlier that there is not a specific SFA body part in that code set. One commenter recommended the CMS should take a broader approach to specify this unique technology if it is (or will become) applicable to a number of other arteries. The participants were encouraged to submit additional written comments on this topic by the November 20, 2009 due date.

2. Reverse Shoulder Arthroplasty

Anand Murthi, MD, facilitated a clinical presentation on a surgical alternative to conventional total shoulder replacement known as reverse total shoulder replacement. The procedure is indicated for patients who are unable to be treated with a conventional total shoulder replacement, such as those with a diagnosis of rotator cuff arthropathy. In the reverse total shoulder replacement, the ball is placed on the glenoid and the socket is placed on top of the humerus. Mady Hue led the coding proposal discussion. Commenters were in support of the proposed new code, 81.88, Reverse total shoulder replacement, to describe this alternative procedure. The new code proposal also included assigning code 81.97, Revision of joint replacement or upper extremity, to identify when conversion of a prior (or failed) total shoulder replacement to a reverse total shoulder replacement occurred. One commenter suggested CMS consider an additional new code to specifically identify the conversion of a prior (or failed) total shoulder replacement to a reverse total shoulder replacement for tracking and quality purposes. Another commenter asked about instructional notes to assist

coders in understanding which components are considered integral to the reverse total shoulder replacement procedure. In response, one commenter pointed out there are existing exclusion terms at subcategory 83.7, Reconstruction of muscle and tendon, that indicate transfer of muscle and tendon associated with arthroplasty is not coded separately. The participants were encouraged to send in any additional comments by the November 20, 2009 due date.

3. Bronchoscopic Bronchial Thermoplasty

Michael Wechsler, MD, provided a clinical presentation on a new bronchoscopic procedure, bronchial thermoplasty, which uses the Alair® System to ablate airway smooth muscle in the lung for the treatment of severe asthma. Pat Brooks led the coding proposal discussion. One commenter questioned how this form of ablation differs from what is currently included in existing code 32.26, Other and unspecified ablation of lung lesion or tissue. This commenter recommended adding an excludes note to distinguish the two if a new code were approved. Another commenter asked how many bronchoscopies are performed for the full treatment. Dr. Wechsler responded that during the clinical trials patients had up to three bronchoscopies performed. One commenter expressed support for the creation of a new code and questioned what other types of ablation exist. Another commenter stated that in previous years, the issue of bronchial constriction appeared to be the focus for treatment of asthma patients and in later years the focus became inflammation. This commenter noted that currently, the shift appears to be going back to a focus on the constriction of the airways. Participants were encouraged to submit additional written comments by the November 20, 2009 due date.

4. Circulatory Support Devices

Daniel Raess, MD, conducted a clinical presentation on the new Impella® 5.0 and Impella® LD® circulatory support devices. The technology relies on an internal impeller to provide increased cardiac output in patients with acute heart failure. Ann Fagan led the coding proposal discussion. Ms. Fagan provided a brief background on modifications that had been made to the category of circulatory assist systems within the last couple of years. She specifically reviewed the various terminologies and the complexity of assigning these newer technologies to adequately distinguish them from existing codes. One commenter questioned how these newer Impella® devices are powered. Dr. Raess stated that the devices have a DC power pack with an external control unit and a motor in the catheter. This same commenter also inquired about aortic valve integrity and hematologic effects. Dr. Raess responded that based on available laboratory and clinical data from studies in both Europe and the U.S., no injury has been sustained as the valve collapses around it, thereby preventing damage to the valve. With regard to any hematologic effects, Dr. Raess noted that as a result of the engineering and innovation, hemolysis does not occur when patients are positioned correctly. Another commenter asked if there should be two new codes to separately identify an open versus percutaneous approach. Dr. Raess indicated the devices are similar enough in their pump action and could be combined into one code. One commenter noted the current inclusion term *Short term circulatory support (up to six hours)* at code 37.62, Insertion of temporary non-implantable extracorporeal circulatory assist device, that is proposed to be deleted could lead to more confusion for coders to try and determine what is meant by

“temporary” in comparison to the newly proposed codes. One commenter asked how these devices are removed. Dr. Raess responded that the patient’s chest must be re-opened to remove the device or catheter within the graft. He also stated it does not require use of the cardiopulmonary bypass machine. Participants were encouraged to review the proposal and submit any additional comments by the November 20, 2009 due date.

5. Carotid Sinus Baroreflex Activation Device

Luis Sanchez, MD, facilitated a clinical presentation on the Rheos carotid sinus baroreflex activation system™, an implantable device designed to electrically activate the baroreflex, the system that helps regulate cardiovascular function. The Rheos System™ is in clinical trials for hypertension and heart failure indications. Amy Gruber led the coding proposal discussion. Ms. Gruber reviewed the current code available to report implantation of the carotid sinus baroreflex activation device, 39.8, Operations on carotid body, carotid sinus and other vascular bodies, as well as additional codes to identify the lead or generator only implantation or replacement and removal of the device. Consistent with the clinical presentation, Ms. Gruber explained that the current code(s) do not uniquely identify that baroreflex activation therapy is vascular surgery and not neurosurgery as the current codes describe. One commenter questioned if the generator is rechargeable. Dr. Sanchez responded it is not rechargeable and does require replacement; the timeframe for replacement varies by patient depending on their energy needs. This same commenter expressed support for the new codes, however, also asked if separate codes were truly needed to identify the “total system” (proposed new codes 39.81 and 39.84). This commenter noted that it appears for ICD-10-PCS that coders will be assigning codes for component parts of a procedure, therefore, this commenter was not certain if codes describing the “total system” were necessary. Another commenter supported the proposal for creating new codes to improve tracking at hospitals for outcomes, quality, readmission rate, and associated complications. One commenter questioned whether the current coding for the insertion or replacement of the pulse generator only should be assigned to code 86.95, Insertion or replacement of dual array neurostimulator pulse generator, not specified as rechargeable instead of code 86.96, Insertion or replacement of other neurostimulator pulse generator. CMS researched this issue and noted that the use of code 86.96 was provided in AHA’s Coding Clinic, Second Quarter 2007. Therefore, this procedure has been captured with code 86.96 for two years. It would be inappropriate to disrupt trend data with a new interim code assignment while CMS considers the creation of a new code. Therefore, CMS continues to recommend the use of code 86.96 for interim coding. Participants were encouraged to submit any additional comments by the November 20, 2009 due date.

6. Addenda

Mady Hue provided a brief background on the addenda process and reviewed the proposed Tabular List and Alphabetic Index updates. One commenter questioned if the inclusion term “via peripherally inserted catheter” at code 37.34, Excision or destruction of other lesion or tissue of heart, other approach, that was proposed to be removed could still remain so that coders would not be confused and think that catheter-based approaches were no longer assigned to that code. Ms. Hue indicated that would be taken into consideration.

Prior to reviewing the proposed spinal fusion code revisions, Ms. Hue explained that these same revisions would also apply to the spinal refusion codes. She also stated that this category of codes presented challenges as both the approach and the technique concepts were historically included in this set of codes and no longer accurately apply in today's environment. Several new techniques have been developed and while creating the proposal to assign these newer techniques to existing codes, another recommendation was also received to identify which column is being fused. Therefore, the proposal addressed both the column being fused and the newer procedure terms. Commenters expressed their support of the proposed spinal fusion/refusion code title revision that would identify which column is being fused. Commenters also supported the EXtreme Lateral Interbody Fusion (XLIF) and Direct Lateral Interbody Fusion (DLIF) inclusion terms being proposed at code 81.06, Lumbar and lumbosacral fusion, anterior technique, versus code 81.08, Lumbar and lumbosacral fusion, posterior technique. Andrew Cappucino, MD, board certified in spinal surgery and orthopaedic surgery specifically stated it is important to distinguish that the XLIF procedure uses a true anterior approach. Another commenter recommended additional inclusion terms of "facet fusion" and "posterolateral" to be added at code 81.07, Lumbar and lumbosacral fusion, lateral transverse process technique. Some commenters commented on other inclusion term proposals of "posterolateral technique" at codes 81.04 and 81.05, Dorsal and dorsolumbar fusion, anterior technique and posterior technique, respectively, and also questioned where a lateral extracavitary approach would be assigned. Dr. Cappucino described the lateral extracavitary approach and agreed it could be considered as an inclusion term at code 81.04. Another commenter suggested adding a space in the proposed note at the spinal fusion category to differentiate between the anterior and posterior column fusions descriptions.

One commenter questioned the Index proposal code assignment for mini-bronchoalveolar lavage (mini-BAL) assigned to code 33.29, Other diagnostic procedures on lung and bronchus, versus code 33.24, Closed [endoscopic] biopsy of bronchus. Ms. Hue indicated she would follow up and include information in the Summary Report. The mini-BAL is a simple, non-invasive procedure and easily repeatable at bedside, therefore, it was proposed to be indexed to code 33.29 versus 33.24.

There appeared to be general support for the remaining addenda items. The participants were encouraged to send in additional comments for consideration and review by the due date.